

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

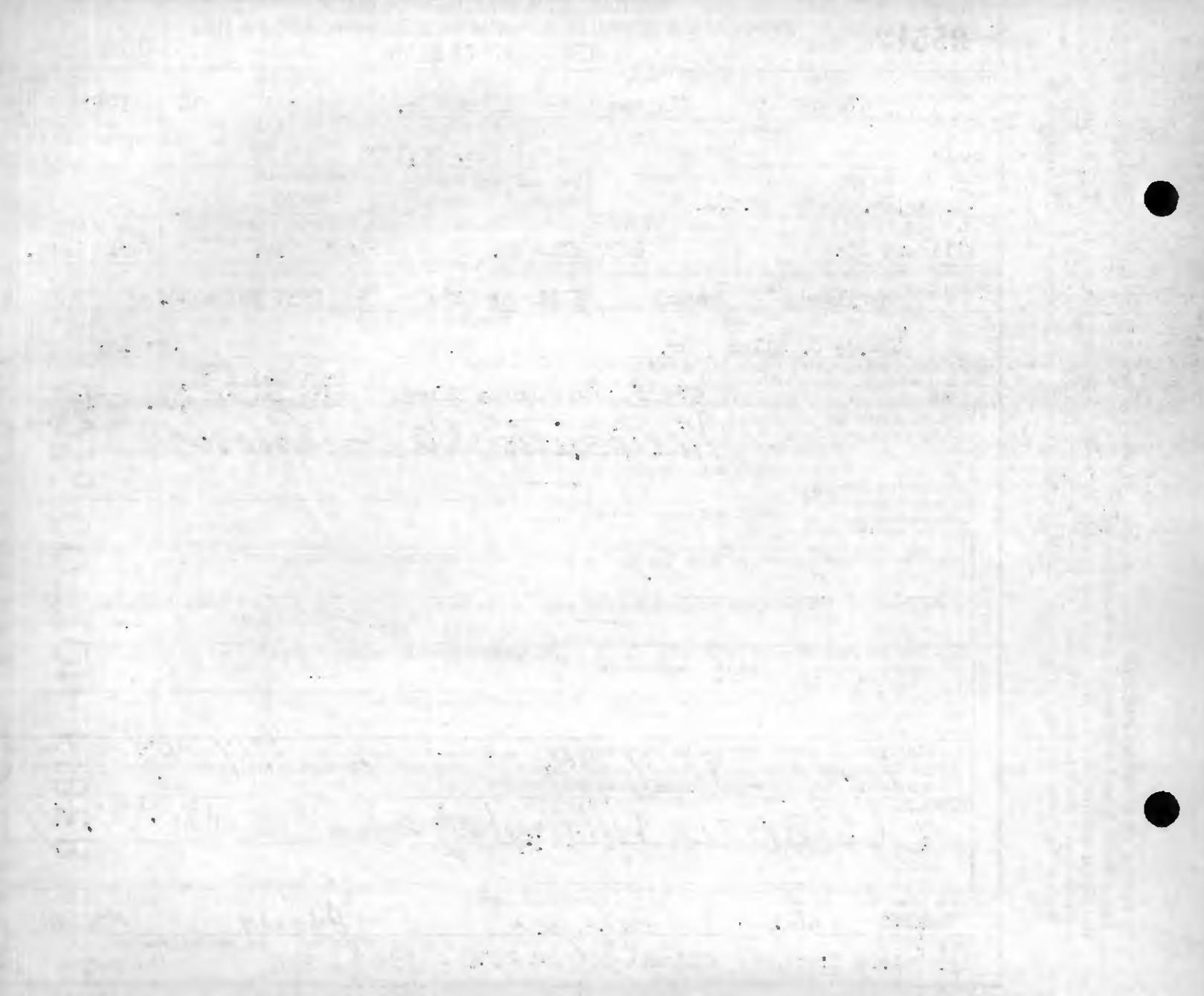
05512

05506

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no later than 24 hours after death.

1. DECEASED-NAME (Type or print)	First Claude	Middle Clayton	Last Allen Jr.	2d. DATE OF DEATH Month April	Day 19	Year 1969	2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH Dec. 30, 1931			6. AGE (in years last birthday) 37 YRS.		
7a. BIRTHPLACE (State or foreign country) Risner, Ky.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard			
10. CITY OR TOWN OF DEATH Ellicott City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2637 Melba Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plant Manager			12b. KIND OF BUSINESS OR INDUSTRY Purex Corp.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2637 Melba Rd.			
14. FATHER'S NAME Claude C. Allen Sr.	15. MOTHER'S MAIDEN NAME Bertha	Middle	Lost	Bradley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 405-58-9696	17. INFORMANT Betty Allen	2637 Melba Rd, Ellicott City, Md. 21043			Address Approximate interval between onset and death	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ca - Colon</i> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1, 1969</i> to <i>4/19, 1969</i> , that (I) (we) last saw the deceased alive on <i>4/9, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Christopher S. Higinbotham</i>		ATTENDING DOCTOR PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/21/69</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 3459 ST. JOHNS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/23/69	23c. NAME OF CEMETERY OR CREMATORIAL Bellevue	23d. LOCATION (City or Town) Arlington		(County) Mich	(State)
24. FUNERAL DIRECTOR Higinbotham Slack		ADDRESS Ellicott City, Md 21043	25a. REC'D. BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05513

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05507

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED		Month	Day	Year	2b. HOUR			
ALBERT			W.	BRADY			<input type="checkbox"/>		19	M				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)			IF UNDER 1 YEAR	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.			
male	white	June 30 1878	90 yrs.											
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH			2c. DATE PRONOUNCED DEAD				
Balt Md		USA		<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard			Month	Day	Year		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Fulton		Fulton, Maryland			Festivator			US Govt						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER				
Maryland		Howard		Fulton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Fulton, Maryland				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S M AIDEN NAME		First	Middle	Last	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Ernest				Brady	Annie Elizabeth Deshago									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
					<input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. UNK P.M. 4/27/19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			smoke						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home			21f. LOCATION Street or R.F.D. No.			City or Town County State						
Fulton, Howard, Maryland														
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>														
EXAMINER'S NAME (Type)														
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION (City or Town)		(County)		(State)			
Burial		5/1/69		St Paul, Lutheran			Fulton, Howard, Md							
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lanier Funeral Home		Md			Charles Jorges		DATE MAY 5 1969							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05514 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05508

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Herbert	Middle Bryant	Last	20. DATE KNOWN OF ESTI- MATED	4	Month 13	Doy 19	Year 69	2b. HOUR 9 M
3. SEX male	4. RACE white	5. DATE OF BIRTH 1899	6. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF HRS. HOURS 0	IF MIN. MIN. 0	2c. DATE PRONOUNCED DEAD Month May	Day 19	2d. HOUR M	
7a. BIRTHPLACE (State or foreign country) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard					
10. CITY OR TOWN OF DEATH Daniels			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box#114 (rural)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) sawmill			12b. KIND OF BUSINESS OR INDUSTRY lumber		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Daniels	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Box#114					
14. FATHER'S NAME First Unknown			Middle 	Last 	15. MOTHER'S MAIDEN NAME First Susan			Middle 	Last Bryant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) ?		17. INFORMANT Howard McCraw		ADDRESS Box#114 Daniels, Md. 21033					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week											
486X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/13/69		
EXAMINER'S NAME (Type)		Charles S. Whitaker, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Howard County				
23a. BURIAL, CREMATION, REMOVAL(Specify) Burial		23b. DATE 4/16/69		23c. NAME OF CEMETERY OR CREMATORIAL Family			23d. LOCATION (City or Town) Sneadserville		(County)	(State) Tenn.	
24. FUNERAL DIRECTOR Higinbotham Slack Funeral Home		ADDRESS Ellicott City, Md.			25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Whitaker</i>				

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STRUCTURE

STRUCTURE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2, and 7, 8, and 9, after death. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal on any event, within 72 hours after death.

05515		CERTIFICATE OF DEATH						05509	
1. DECEASED NAME (Type or print)		First <u>OLIVE</u>	Middle <u>.Amy</u>	Last <u>BURDETTE</u>	2a. DATE OF DEATH Month <u>APRIL</u>		Day <u>25</u>	Year <u>1969</u>	2b. HOUR <u>9 3/4 P.M.</u>
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 28, 1884		6. AGE (In years last birthday) 84		IF UNDER 1 YEAR MONTHS 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard		IF UNDER 24 HRS. HOURS 0	
10. CITY OR TOWN OF DEATH Fulton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Simon Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 28031 Ridge Rd.	
14. FATHER'S NAME First William Edward Warthen		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Olive Ann Reed		Middle 	Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Albert E. Warthen, Damascus, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		HEPATIC FAILURE 5719							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.		1 MONTH							
DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS OF THE LIVER		10 YEARS							
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
CEREBRAL ARTERIOSCLEROSIS C SPASTIC QUADRIPLIGIA									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month APR Day 25 Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. CLARKSVILLE City or Town MARYLAND County Howard State Md.					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 4, 1960 , to APR 25, 1969 , that (I) (we) last saw the deceased alive on APR 18, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles S. Whitaker, M.D.		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4/25/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS CHARLES S. WHITAKER, M.D.		22f. ADDRESS CLARKSVILLE MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 28, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Montgomery Meth.		23d. LOCATION (City or Town) Clagettsville, Md.		(County) (State)	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS		25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

7120

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05510

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Release of Body Medical Examiner

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 10:40 AM
Matthew J. Chambers				April 10, 1969	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male	White	Feb. 27, 1880		89 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Maryland	U. S. A.	Howard County, Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Ellicott City, Md.	51 Maryland Avenue		Boiler Maker		B. & O. R.R.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Howard	Ellicott City		(Maryland) 51 Maryland Ave.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
William H. Chambers				Catherine Daley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Catonsville, Md. 21228		
No		Robert M. Schatz	117 Bloomsbury Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>5-22</u> , 19 <u>67</u> , to <u>10-10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-24</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thomas P. Herbert, MD</i>	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4-12-69
22d. PHYSICIAN'S NAME (Type) <i>Thomas P. Herbert, M.D.</i>	22e. ADDRESS 3779 Church Rd, 911-9866 Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE 4/14/1969	23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cemetery	23d. LOCATION (City or Town) Ellicott City, Md.	(County)	(State)
24. FUNERAL DIRECTOR <i>Easton Funeral Home</i>	ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE <i>Clara L. Under</i>	

87500

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05511

05517

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First HUBERT	Middle L.	Lost HARR	2a. DATE OF DEATH APRIL Month 28 Day 1969 Year	2b. HOUR DOA M						
3 SEX Male		4. RACE White		5. DATE OF BIRTH Sept 14, 1943		6. AGE (in years last birthday) 25 yrs.	IF UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN		
7a. BIRTHPLACE (State or foreign country) Ft Necessit, La		7b. CIT ZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard						
10. CITY OR TOWN OF DEATH Savage		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) Berger Road		12a. USUAL OCCUPAT-ON (Kind of work done during most of working fe, even if retired) Serviceman		12b. KIND OF BUSINESS OR INDLSTRY U.S. Army						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res dence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Severn		13d. INSIDE C TY (IN TSP) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7 & Old Meade Rd, Apt 7					
14. FATHER'S NAME First John		Middle Harr	Last	15. MOTHER'S MAIDEN NAME First Thelma		Middle	Last Rodgers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO 1967 - 1969		17. INFORMANT Personnel Record, Ft Geo G. Meade, Md		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (c) 8167						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH within 5 min						
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.		Due to, or as a consequence of (b)										
		Due to, or as a consequence of (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Caused by automobile accident												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 4:15 AM Apr 28 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) In an auto which went off road and overturned								
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) Street		21f. LOCATION Street or R.F.D. No Berger Rd, Savage, Howard, Maryland		City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DOA 1969, to 28 Apr 1969, that <input checked="" type="checkbox"/> (we) last seen the deceased <input checked="" type="checkbox"/> in DOA 28 Apr 1969, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death												
22b. SIGNATURE Joseph H. Wear, MD		22c. DEGREE DEGREE		ATTENDING PHYS.		MED DIRECTOR		STAFF PHYS		22d. DATE SIGNED 28 Apr 1969		
22e. PHYSICIAN'S NAME (Type) JOSEPH H. WEARN, MD, MAJOR		22f. ADDRESS US KIMBROUGH ARMY HOSP, FT MEADE, MD										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 30 1969		23c. NAME OF CEMETERY OR CREMATORIAL Alexandria Nat'l		23d. LOCATION (City or Town) Pineville La.		(County)			(State)	
24. FUNERAL DIRECTOR Howard County Funeral Home Harry Witzke		ADDRESS Ellicott C Maryland		25a. REC'D. BY REGISTRAR DATE MAY 2 1969		25b. FINGERPRINT SIGNATURE joseph h. wear						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

05518 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05512

1. DECEASED-NAME (Type or Print)	First Baker	Middle Samuel	Last Singhass	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4 / 1 1969 2b. HOUR 5 P. M.	
3. SEX male	4. RACE white	5. S. DATE OF BIRTH 3/11/1892	6. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	12c. DATE PRONOUNCED DEAD Month 4 Day 1 Year 1969 2d. HOUR 5 P. M.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Howard		
10. CITY OR TOWN OF DEATH Ellicott City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3497 Rogers Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) painter	12b. KIND OF BUSINESS OR INDUSTRY D.C.A.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 3497 Rogers Ave.					
14. FATHER'S NAME Christian J. Singhass	First Christian J.	Middle Singhass	Last Stump	15. MOTHER'S MAIDEN NAME Lena	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. W.W.I	17. INFORMANT Mary B. Singhass	ADDRESS 3497 Rogers Ave, Ellicott City, Md. 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1954 and 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Thomas F. Herbert</i>		CHIEF MEDICAL EXAMINER M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED 4-3-69	
EXAMINER'S NAME (Type) Thomas F. Herbert M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	ADDRESS (Street, city, town, or county) Ellicott City Howard Md.		
23a. BURIAL, CREMATION, REMOVAL, ETC. Burial	23b. DATE 4/4/69	23c. NAME OF CEMETERY OR CREMATORIUM Good Shepherd	23d. LOCATION (City or Town) Ellicott City Howard Md.	(County) (State)	
24. FUNERAL DIRECTOR Higinbothem Slack		ADDRESS Ellicott City, Md.	25a. REC'D BY REGISTRAR APR 9 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First FLORENCE	Middle G	Last TAYLOR	2a. DATE OF DEATH Month 4 Day 28 Year 69	2b. HOUR 6:15 A
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 5/14/93		6. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN
7a. BIRTHPLACE (State or foreign country) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	9. COUNTY OF DEATH HOWARD COUNTY		
10. CITY OR TOWN OF DEATH ELLIOTT CITY, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) TAYLOR MANOR HOSP	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE BALTO. MD.	13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Broadview Apts.	
14. FATHER'S NAME Francis	First X	Middle Guberlet	15. MOTHER'S MAIDEN NAME Mary	Middle E	Last Hughes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Dr Paul Taylor 270 Cascade Rd Pitts. Pa	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4122 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 Days		
(b) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Arterial Sclerotic Cardio Vas. Dis.			2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1969, to 4/28, 1969, that (I) (we) last saw the deceased alive on 4/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Fisher, M.D.		22c. DATE SIGNED 4/28/69			
22d. PHYSICIAN'S NAME (Type) ROBERT FISHER, M.D.	22e. ADDRESS Taylor Manor Hospital, Ellicott City, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/1/69	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Leonard J Ruck Inc	ADDRESS Baltimore, Maryland	25a. REC'D BY REGISTRAR APR 29 1969	25b. REGISTRAR'S SIGNATURE John Charles Jagger		

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